

Version Control Sheet

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Author	Anna Garner
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SERVICE SPECIFICATION

Service	End of Life Care (EOLC)
Commissioner Lead	Anna Garner
Provider	GP Confederation
Provider Lead	City and Hackney CCG
Period	1 April 2017 – 31 March 2019 Total 24 months
Date of Review	November 2017

1 Population Needs

Around half a million people die in England each year, of whom almost two thirds are aged over 75. The large majority of deaths follow a period of chronic illness such as heart disease, cancer, stroke, chronic respiratory disease, neurological disease or dementia. Most deaths (58%) occur in NHS hospitals, with around 18% occurring at home, 17% in care homes, 4% in hospices and 3% elsewhere (Department of Health, 2008). The proportion of deaths in hospital is falling and in 2013 was 48% nationally (Department of Health, 2014). In the national VOICES survey in 2013, of those surveyed, only 32% expressed a preference to of location of death, and of these, 79% stated a preference to die at home.

Palliative and End of Life Care Networks have played a central role in prompting, coordinating and supporting local efforts to implement and embed the Priorities for Care

and the learning from One Chance to Get it Right (Department of Health, 2015) to ensure that we provide quality care in the last few years of life.

In City and Hackney, we know that in 2013/14, 43% of people at end of life care die in hospital and 43% die out of hospital (see annex one) and we are seeing a downward trend in the proportion of people dying in hospital.

The service will support people who:

- Have a terminal cancer diagnosis and are predicted to be in the last 2 years of life
- Have one or more long term conditions and are at high risk of admission/predicted to be in the last 2 years of life and are included in the FHV contract (this contract covers extra elements to the FHV contract i.e. advance care planning)
- Have one or more long term conditions and are at high risk of admission/predicted to be in the last 2 years of life but are not included in the Frail Home Visiting GP contract (housebound is not a criteria for eligibility)

2 Outcomes

The outcomes related to this specification, relate to meeting the needs of those individuals at the end of life and supporting their families and carers.

NHS Outcomes Framework domains & Indicators

1	Preventing people from dying prematurely	
2	Enhancing quality of life for people with Long term conditions	x
3	Helping people recover from episodes of ill health or following injury	
4	Ensuring people have a positive experience of care	x
5	Treating and caring for people in safe environment and protecting them from avoidable harm	

3 Scope of Service

Aim of the contract:

To encourage GP's to identify those patients who may be in the last year of life and to offer them an opportunity to create an Advance Care Plan (ACP) and to record the details of this on CMC if the patient agrees to do so.

Evidence from Coordinate My Care suggests that those patients who have an ACP are more likely to die in their preferred place of death and to avoid unnecessary hospital admissions.

3.1 Service model

1. Each practice should have a Lead GP for End of Life care. This GP should attend a training session on End of Life care once every 3 years and this training should include refresher training on the use of CMC (this could be online training, attending an educational meeting, or meeting with the local CMC coordinator), to cascade information to other practice staff and to be the practice lead contact for St Joseph's Hospice.
 2. Practices should actively identify those patients who may be in the last year of life (using the SPICT tool or other means). The following web address links to the SPICT tool, which is a guide to identifying people at risk of deteriorating and dying.
<http://www.scotland.gov.uk/Resource/Doc/924/0111396.pdf>
 3. Practices should code patients as Palliative Care to create a register – as per template (8BAe).
NB: this code is a QOF code and so will put patients on the QOF Palliative Care register.
 4. Practices should offer patients information about their disease trajectory (if appropriate), and offer the opportunity to create an ACP (should be recorded when patients have been offered an ACP, and whether they accepted or declined), which should be recorded on CMC (once the patient has consented, the details can be entered onto the CMC by a non-clinician and then approved by a clinician once entered i.e. the GP does not have to enter all the information). The ACP needs only to be a simple ACP but should include at least the following:
 - Preferred place of care
 - Preferred place of death
 - A discussion about resuscitation and the circumstances in which the patient and/or the health care professional feel it would not be appropriate. This could result in a DNACPR form on CMC
 - Any other patient wishes
- This information can be recorded on the City and Hackney Care Plan if the patient does not wish to create a CMC record. If patients require more support to create an ACP they should be referred to PCPCS or Palliative care CNS or another service if appropriate e.g. dementia Advisor. Patients should be supported to create an ADRT if they wish to do so. The CMC record does not have to be created or updated by the GP (this can be done utilising practice administrative staff) but would usually need to be approved by the GP.
5. The ACP and CMC record should be reviewed at least once a year.
 6. Patients should be supported to die at home if they wish to do so. This would involve being willing to visit the patient at least every 2 weeks (once patient is thought to be in their last month of life) so that the death certificate can be issued when needed (patients can be included on Frail Home Visiting GP contract if they are housebound as these home visits should be funded via this contract). It would also involve liaising with nursing teams, social services and other clinicians as appropriate and being willing to discuss the ACP with family members and carers if the patient gives consent.
 7. Patients on the palliative care register should be discussed at the monthly practice Multi-disciplinary team (MDT), as appropriate (which should ideally be attended by palliative care

Clinical Nurse Specialist (CNS), if possible). A random audit of minutes will be carried out by the CCG to evidence this.

8. Practices should notify the Out of Hours GP service about palliative care patients using either a special patient note or CMC

3.2 Care Pathways

The GPs and the GP Confederation will work collaboratively with other services across the system including NHS acute providers, voluntary sector organisations and Hospices, including St. Josephs, Marie Curie, Age UK, Homerton University Hospital and others.

Acceptance criteria will be those identified as end of life care using the SPICT or other appropriate tool.

3.3 Structural Support

The GP Confederation will work with all GP practices across City and Hackney to deliver support to individuals in the last few years of life as outlined in the service specification.

4 Applicable Service Standards

NICE Guideline (NG31) Care of Dying Adults in the last stages of Life.

5 Key Performance Indicators

Outcomes

The service is expected to support the following improvements:

- Reduction in Emergency admissions at end of life
- Reduction in Length of Stay (LOS) at end of life
- Increased proportion of patients dying in preferred place of death

To assess performance of the service, the following KPIs/quality standards will be used:

- Creation and number of patients on last years of life register (source: CEG)
- Number of patients with Advanced Care Plan (ACP) recorded (source: CEG)
- Number of patients with Co-ordinate My Care (CMC) record (source: CMC)
- Number of patients with DNACPR and/or ADRT (source: CEG)
- Proportion of patients achieving preferred place of death (source: Public Health Mortality Files and CMC)
- Number of patients who die per practice, number who are end of life and of those, the number who die in their preferred place of death (source: CEG).

6 Reporting Requirements

Practices are asked to use the CEG Palliative Care template to record the following:

1. Patient may be in last year of life – template: anticipatory palliative care 8BAe
2. Advanced Care Plan (ACP) discussion (either code plan drafted or declined by patient)
3. Co-ordinate My Care (CMC record (either code consented or declined)
4. DNACPR (not for resuscitation) discussion (code discussion had with patient)
5. Place of Death/Place or preferred death

Templates will be produced and distributed to the GP Confederation and the CCG by CEG.

The CCG will also monitor what proportion of patients on the palliative care register (i.e. those predicted to die within a year) die each year. *NB: this data is just for information purposes, practices will not be penalised on the outcome of this.*

Practices could be asked to provide minutes of their monthly practice MDT as evidence of patients being discussed (CCG to carry out random audit, as above).

The KPIs will be reported to the EOLC Programme Board which meets quarterly and will be reported to the Crisis Care Board

The End of Life Care clinical and management leads will meet with the GP Confederation clinical and contract leads on a quarterly basis.

7 Financial and Procurement Summary

The GP Confederation will be paid £110 per patient on the practice palliative care registers with completed template (including above points 1-4 coded), as long as there is, for each practice:

- A last years of life GP lead
- A minimum of 2 patients per 1000 of the whole practice list has completed palliative care templates (0.2%)
- A maximum of 5 patients per 1000 of whole practice list has completed palliative care templates (0.5%)
- If practices cannot meet this target because of e.g. having a younger practice population, practices will need to provide evidence of attempted case finding to meet the minimum target

And therefore a minimum of 608 and a maximum of 1519 patient templates are completed across City and Hackney, based on a registered population of 303,884 (CEG, April 2016).

NB: This payment is only covering the criteria in the service specification above, not home visiting (covered by core contract for patients as end of life and the Frail Home Visiting contract). As above, if patient identified as end of life and eligible for this contract becomes housebound then they also become eligible for Frail Home Visiting Contract and so can attract payment via that contract.

Total contract capped at £162,000 per annum pro rata

2017/2018 = £162,000

2018/19 = £162,000

8 Proposed Contractual Terms

8.1 Type of contract proposed (NHS Standard contract, Grant agreement, Alliance contract): Contract with GP Confederation

8.2 Service Commencement date: 1st April 2017

8.3 Contract duration: 24 months (review after 12 months)

8.4 Interdependencies with other City and Hackney CCG and National GP contracts

Patients may be included in this contract and the Frail Home Visiting GP contract (if patients are housebound and deemed to be in the last year of life) and the Avoiding Unplanned Admissions DES. There will also be patients that are eligible for one of these contracts but not the other.

Establishing a register of all palliative care patients and regular discussion at multi-disciplinary case review meetings are included within the National QOF. Therefore patients within this contract will also attract payment for QOF (as both of these elements are within this contract) – however this contract also covers having conversations about advance care planning, sharing ACPs via CMC and coordination of support for patients including dying at home if wanted. These elements are therefore extra to the work paid for via QOF.

9 References

Department of Health (2008) End of Life Care Strategy Promoting high quality care for all adults at the end of life https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136443/EO_LC_exec_summ.pdf

Department of Health (2015) National End of Life Care intelligence network, What we know now, 2014
http://www.endoflifecare-intelligence.org.uk/resources/publications/what_we_know_now_2014

NICE (2015) Care of dying adults in the last days of life (NG31) <https://www.nice.org.uk/guidance/ng31>

National Survey of bereaved people (VOICES) 2013, published 2014.
<http://www.ons.gov.uk/ons/rel/subnational-health1/national-survey-of-bereaved-people--voices-/2014/index.html>